

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED AUG 15 1962

=62-028282

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 196

STATE FILE NUMBER

VS 300  
Rev. 4/59

6928  
8928

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CHARLES</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>4 DAYS</u>		c. CITY OR TOWN <u>ST. CHARLES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH HOSPITAL</u>			Inside/Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>94 ROSEWOOD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>RAYMOND</u> Last <u>EMKEN</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>22</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 5, 1891</u> 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>UNKNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>SWINDELL</u>		14. NAME OF HUSBAND OR WIFE <u>NELLIE GAIL EMKEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/O</u>				16. SOCIAL SECURITY NO. <u>[REDACTED]</u>		17. INFORMANT <u>SNELLIE GAIL EMKEN</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> <u>with congestive heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>and bronchopneumonia</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u>8:05P</u> Month, Day, Year <u>7/18/62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>7/18/62</u> to <u>7/22/62</u> and last saw him alive on <u>7/22/62</u>		Death occurred at <u>8:05P</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>G. C. Gaeger, M.D.</u> (Degree or title)				22b. ADDRESS <u>304 So. 2nd, St. Charles, Mo.</u>		22c. DATE SIGNED <u>7/23/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>7-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CROCKER MEM. Cem CROCKER, MO.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>MOSS-WILLIAMS CROCKER, MO</u>				25. DATE RECD. BY LOCAL REG. <u>7-23-62</u>		26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

2967 C T 577 SE

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence Prosser

Licensed Embalmer No. 4896

P. O. Address Waynesville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.